RESEARCH

MANUAL HANDLING POLICIES –

DO THEY REALLY WORK?

Many hospitals/trusts have systems in place to comply with the Manual Handling Operations Regulations 1992. But, have you ever wondered how effective these systems are at reducing musculoskeletal symptoms, associated absence and litigation?
In partnership with the Medical Research Council and the Roben's Institute, ANHOPS plan to carry out a survey of a large number of hospitals in the UK. This study addresses the issue of manual handling strategies and will measure important outcomes such as accidents, absence, litigation and musculoskeletal symptoms. We hope that the results will be of practical use to ANHOPS members and their NHS employer(s). The research will be most useful if a large number of UK hospitals take part, including a mixture of large and small trusts and a variety of models for occupational health input and wider manual handling strategy. WE REALLY NEED YOUR HELP TO RECRUIT AS MANY HOSPITALS AS POSSIBLE.
I will shortly write to all ANHOPS members about the study. Please help us by taking part. This will involve very little work for you personally. Your role will be to introduce us to someone in your trust who knows about manual handling strategy, and (most importantly) to encourage them to take part.

Manual handling is one of many areas of risk management in the NHS for which we have a relatively limited evidence-base. ANHOPS is well placed to facilitate research in this area. Please help us with this important work, by replying to my letter in due course. If you do not receive a letter within the next month and are interested in taking part then please contact me at the MRC Unit in Southampton.

MRC Medical Research Council

ROBENS Institute

ANHOPS ASSOCIATION OF NATIONAL HEALTH OCCUPATIONAL PHYSICIANS

Dr. Julia Smedley, MRC Environmental Epidemiology Unit, Southampton General Hospital, SouthamptonS016 6YD
Email jcs@mrc.soton.ac.uk
Tel: 023 8077 7624 Fax: 023 8070 4021

RESEARCH BURSARIES

ANHOPS

Research Bursaries 2001

revised deadline for applications

The Executive Group has devoted some funding, in the form of Bursaries, to support research and audit in the field of Occupational Health in Health Care Workers. Two ANHOPS Bursaries, each of £500, will be available to two successful applicants. The funding must be used to support original research or good quality audit, preferably facilitating the production of evidence-based ANHOPS guidelines in a defined area of practice. Appropriate use of the funding would include (for example) purchasing equipment, statistical advice, laboratory or hygiene measurements. However, the bursaries are not intended to support recurring manpower costs.

Applications will be judged by the ANHOPS Research and Education Committee. Applicants must be a member of ANHOPS. All ANHOPS members are welcome to apply, although preference will be given to Specialist Registrars for work leading to completion of an MFOM dissertation. Further details, including an application form can be obtained from Dr J C Smedley, at the contact address in the box above.

The revised closing date for receipt of completed applications for 2001 bursaries will be 31st July 2001. If the initiative is successful it may be repeated on an annual basis.

For more information, please contact...
Dr Alison Rimmer
Sheffield Occ. Health Service
Northern General Hospital NHS Trust
Herries Rd., Sheffield S57AU

Phone: 0114 271 4161

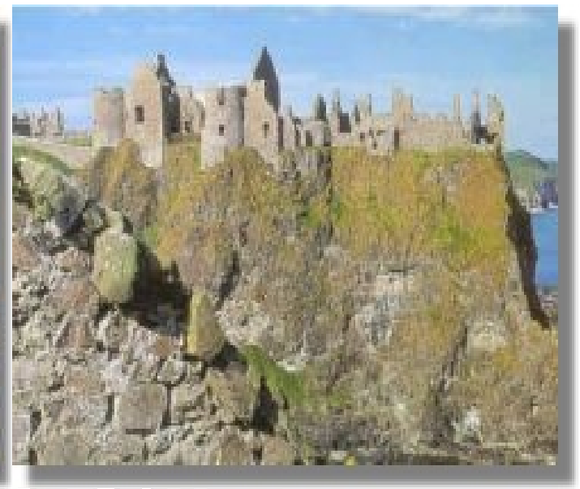
ANHOPS

TAKING OCCUPATIONAL HEALTH FORWARD

APRIL 2001

Anhops News

THE VOICE OF OCCUPATIONAL HEALTH IN THE NHS



POSTCARD FROM NORTHERN IRELAND

It's not often that we go overseas for the Annual Scientific Meeting of the Society of Occupational Medicine. This year both SOM and ANHOPS members have the opportunity to sample the legendary hospitality of the Northern Ireland Group, as well as enjoying the excellent scientific programme that has been put together.

The SOM's ASM will be held between June 26th and June 29th. The programme should have something of interest for everyone who attends. There is certainly plenty for NHS occupational health practitioners.

The first session is devoted to ANHOPS and will be chaired by Anne Ross. Topics will include haematological malignancies, investigation of ischaemic heart disease and HIV infection. Later in the week there will be talks on the management of influenza in the workplace, national surveillance of sharps injuries, diabetes and employment, the sick doctor and the occupational health needs of primary care.

Health promotion in the workplace will feature presentations on the health promotion agenda and prostate cancer screening. There will be the opportunity to hear original papers presented.

The closing lecture will be COMMUNICATING RISK by Professor Brian Toft, which will bring what should be a stimulating conference to a close.

INSIDE THIS ISSUE..

FROM THE CHAIRMAN OF ANHOPS: Dr Anne Ross

CHAIRMAN'S REPORT

Everyone I talk to in Occupational Health is very busy these days. The speciality has a very high profile at the moment. 'Securing health together' gives us an insight into the Government's ten year occupational health strategy with challenges to reduce work-related ill health and sickness absence, to reduce ill health both to workers and the public due to work related contamination of the environment and to increase employment of the disabled. There is a lack of baseline values and we will have to look within our organisations working closely with Human Resources and Risk Management to develop these before we can demonstrate any improvement.

NHS Occupational Health services will play an important part in these aims, often through NHS Plus. Plans are well advanced for this to be launched in the Autumn. A useful meeting was held in Birmingham at the end of February, mainly for Occupational Health NHS nurses who appeared keen to be involved. However, strict conditions for departments to take part in the scheme have been drawn up to ensure good standards of operation and also that the primary role of the services to the NHS does not suffer. The conference in the afternoon indulged in 'futurising' in occupational health. It is recognised that there is a lack of trained Occupational Health doctors and nurses and we will have to think laterally employing technicians and other staff to provide services under careful supervision.

Our combined conference with ALAMA took place in March. An excellent attendance, in spite of the northerly situation, contributed to a first-class meeting. We hope these combined meetings continue to be successful as it gives us a chance to widen our occupational health knowledge. The only slight shadow was the aggressive behaviour of certain ANHOPS members in response to booking difficulties. Please discuss any such frustrations with me or the management group, rather than with "outsiders". We are holding an ANHOPS Spring Meeting in 2002 in London, but I would like feedback on the combined meetings so we can plan for the future. Tony Stevens has done sterling work in organising the SOM Conference and has helped us set up a great clinical afternoon for ANHOPS on the Tuesday. This session will also be open to SOM members. ANHOPS will cover the cost of the Tuesday afternoon as we are very aware of the expense in getting to Ireland. We hope members will stay on and attend some, if not all, of the SOM Conference. We deliberately have arranged a clinical update as CME analysis suggests Occupational Health Physicians are not getting enough general medical sessions. The Annual General Meeting will be held at 5 o'clock on Tuesday. Our November meeting will be, as usual, in Birmingham in November.

There appears to be considerable problems associated with healthcare workers from overseas and I have had feedback on my article. Consultants appear to agree that a risk assessment is vital if they are to do exposure prone procedures and if they come from a high-risk country, HIV testing should be considered. In order not to discriminate, this risk assessment should also apply to everyone and staff going abroad to these countries, who will return to do EPP's in this country, need to be gently reminded of their obligations and the General Medical Council requirements for them to assess what risks they have been exposed to. Consideration should be given as to whether or not we need to give them post exposure prophylaxis to take with them to use in case of needlestick injuries. More recently, we have become aware of the risk of some workers who are exposed to chickenpox as they may not have encountered this as children in their own countries.

Revalidation looms! I have been asked to help with the GMC pilot study and the information one is required to give is considerable. Certainly, details of what you do, lectures you give etc. need to be carefully collected as you do it. It will be too late when the five-year mark comes up. There are definite references to audit and exact details are requested with results. It is,

ATTENTION !!!

"Everyone I talk to in Occupational Health is busy, these days"

SECURING HEALTH TOGETHER gives us an insight into the Government's 10 year occupational health strategy.

Our combined conference with ALAMA was a great success

There appears to be considerable problems associated with healthcare workers from overseas.

The challenge of occupational health in Primary Care Trusts is imminent. Care needs to be taken. There are not enough resources for it to be done directly in every area.

Revalidation looms. It is very important that all OH physicians take part in audit, even if you are doing one session a week.

I took part in the GMC pilot study: the information required is considerable.

From the REGIONS

REGION	Name
Wales	G Denham
Scotland	J Morrison
N Ireland	L Rodgers
North/Yorks	C English
North-West	J McNamara
Trent	I Aston
Anglia	N Irish
West Midlands	vacant
North Thames	vacant
South Thames	N Mitchell-Heggs & J Carruthers
Oxford	A Ross & M Roberton
Wessex	vacant
South West	G Woodroof

Are you interested in standing for the post of Treasurer? B Platts will standing down from his post and nominations are being sought. Please contact the Ex. Committee.

EXECUTIVE COMMITTEE MEMBERS

NAME	TITLE	ADDRESS
Anne Ross	Chairman	West Berkshire OH
Peter Verow	Past Chairman	Sandwell 01216073417
Alison Rimmer	Secretary	Sheffield 01142714161
B Platts	Treasurer	Kings Mill Ctre, Sutton in Ashfield, Notts.
A Robertson	Education	Birmingham 01212233762
J Harrison	Newsletter	Newcastle 01912228748

Salaries for Trainee Occupational Physicians

Every April, the BMA publishes a salary supplement to "The Occupational Physician", which recommends minimum pay scales for occupational physicians, including trainees. These are *"based on those paid to hospital doctors employed in the NHS as recommended…by the Review Body on Doctors' and Dentists' Remuneration"* but are for *"occupational physicians working **outside** the NHS"*. The Department of Health has offered junior doctors a new contract and a new system of pay for out of hours work (April 2000). The proposed changes are based entirely on out-of-hours work. Therefore most NHS SpRs in occupational medicine will remain on the basic, unenhanced SpR scale. A questionnaire was designed to gather the views of OH trainees on the actual range of salaries paid, whether there is a discrepancy between NHS trainees and their non-NHS counterparts, and if so what people feel about this is. The results of the survey were intended to inform the BMA occupational health committee and enable recommendations to improve consistency in remuneration for trainees, and possibly enhance recruitment.

The questionnaire was circulated to around 44% of all SpRs in approved training posts and responses were received from two thirds of those approached, representing around 30% of the total. The responses were almost evenly split between NHS and non-NHS trainees, allowing a fair comparison, but non-NHS trainees were relatively under-represented as a proportion of the whole.

It appears that a pay differential does exist between NHS trainees and their non-NHS counterparts. This is difficult to quantify precisely because of the salary bands used to collect the data. The majority of trainees in both groups took a drop in income on entering the specialty. Opinion about the acceptability of this seemed to be approximately equally split. A high proportion overall had previously worked in General Practice. Only a minority (15%) of SpRs in either group undertook out of hours work. Apart from market forces, there appears to be little justification for setting pay scales for non-NHS SpRs 8% above those in the NHS.

OVER AND OUT

This is my last Newsletter. I have enjoyed editing and producing it. I have learned a lot about desk-top publishing and printing. Thanks to everyone who has contributed text and ideas. If at least some of you have enjoyed reading it, it's been worthwhile. John.

INFORMATION & EDUCATION

JOB RETENTION AND REHABILITATION PILOTS

"Its Occupational Health, Jim, but not as we know it"

Bidding for the Ideas phase of the Job Retention and Rehabilitation Pilots closed on 30th March, and a number of NHS Occupational Health Departments are expected to emerge as partners or lead bidders in the possible areas of the generic pilot, as defined by the populations of the Health Authority/ Boards of Leicestershire, Sheffield, Birmingham, lechyd Morgannwg, Greater Glasgow, Wiltshire, West Kent, East Kent, Tees, Newcastle and North Tyne.

A separate mental health focussed pilot will operate in North and South Cheshire and Wirral.

The pilots are about testing healthcare and workplace interventions at six weeks of certification to keep disabled people in work, and obtaining data on the cost-effectiveness of health and employment strategies to inform any longer term decisions about investment in job retention services.

These approaches will be tested by random allocation individually and together, and against a control group, to produce robust data; this evaluation will be complemented by more traditional methods running in parallel. The mental health pilot will cover the full spectrum of mental health and because of the smaller numbers, only the combined intervention strategy will be used.

Informed consent is an important feature of the JRRPs, so that those allocated to the control group will understand that they still have access to the full range of services under NHS, and be covered by the DDA.

- The first stage of the procurement process asks for innovative ideas and seeks evidence of collaborative work.
- The second, feasibility stage will be under contract to DfEE, and will be followed by
- a third stage of implementation planning leading to live service delivery in 2001.

£12M has been set aside for the two pilots, plus the over-arching evaluation which is expected to take up a significant part of this – perhaps up to 25%; however this work is innovative and bids should reflect its' true cost. The JRRPs offer an opportunity for organisations to work in partnerships crossing the traditional boundaries of health and employment, participating in and influencing leading edge national policy; they also offer opportunities for employers and healthcare professionals to obtain access to additional resources for their patients and employees.

As in previous initiatives, JRRPs also offer an opportunity for NHS O/H departments to demonstrate their role in providing clinical leadership in combating unemployment, which must rank as one of the most serious of occupational diseases, as well as causing social exclusion and lead to poverty.

Further details can be found at http//:www.dfee.gov.uk/nddp, or by contacting Jim Ford, Medical Director JRRPs, Room N8, Moorfoot DfEE, Sheffield S1 4PQ. Jim.FORD@dfee.gsi.gov.uk TEL:01142591014

Jim Ford.

Inside this issue:

STOP PRESS

ANNUAL SCIENTIFIC MEETING, BELFAST

JUNE 26–29

The ANHOPS Annual General Meeting will take place at the end of the scientific session on Tuesday, June 26th, 2001.

The meeting will start at 1700 hrs and will be a members-only meeting.

SEE YOU THERE!!

therefore, very important that all OH Physicians, even if you are doing one session a week, take part in audit. We are encouraging the development of local groups and managers need to allow doctors time to attend.

The challenge of occupational health in Primary Care Trusts is imminent. Monies from the Department of Health have already been passed to the Health Authorities. There has been a strong suggestion from the Department of Health that NHS units are involved in providing services. Care needs to be taken. There are not enough resources for this to be done directly in every area and GPs with an interest in occupational health will need to be involved. However, some appear to have little insight into the ethical problems of being an Occupational Health Physician in services where there are already managers and General Practitioners to their staff. Some of the arrangements that have been put in place to get round these ethical dilemmas need careful questioning. There is a need for education and support recognising that the type of service might be different from that given to the hospitals. Care should be taken, however, to make sure that you are not just a service to which problems may be referred without you having any input into standards of the service. If you are encountering problems, please let us know and we will endeavour to help with our contacts in the Department of Health, especially if they are widespread.
Hope to see you in Belfast.

NHSplus– Launch

You should all have heard by now that NHS PLUS is coming! I have spoken to many of you personally and many are fully in the picture and getting ready for the start.

Points to note: -

- We are not setting up a **new** service. We want as many existing NHS Occupational Health Departments as possible to sign up as NHS PLUS suppliers.
- Being a NHS PLUS supplier means that you are a NHS occupational health department selling occupational health services to the private or other parts of the public sector.
- You may be a big Department with a large turnover of privately generated income offering a full OH service. You may be a small Department with just a bit of income generation offering a limited OH service. Either way, you are welcome as part of NHS PLUS.
- You must, however be providing a good service to your own NHS staff and be operating to good professional practice standards. More information about this will be supplied before you join NHS PLUS.
- The service does not have to be supplied by a doctor but your Department must have a fully qualified OH doctor who you can refer cases to if necessary.
- We shall be setting up a data base of NHS PLUS services in the early summer and putting the information on a Web-Site which employers can access. **SO SEND YOUR DETAILS TO THE ADDRESS BELOW.**
- We shall be holding a big National Conference in the Autumn to launch NHS PLUS.
- We then hope that NHS PLUS will grow steadily as you all have the opportunity to network and share ideas and the profile of this important service is raised. We shall do all we can to encourage more staff to specialise in Occupational Health but clearly the shortage of OH staff will be the major constraint.

Being part of NHS PLUS will give you access not only to the publicity and marketing opportunities of the Web-Site but we also plan to supply central information and training in matters such as new OH developments and business management.

Mrs E J Johnson
Programme Manager
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Department of Health
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Fax : 020 7972 4425

e-mail : elizabeth.johnson@doh.gsi.gov.uk

ANHOPS REVIEW

PAPERS REFERENCES

Subscribers to *OCCUPATIONAL MEDICINE* will be aware of the IN-DEPTH REVIEW series. ANHOPS members contributed to the recent review of biological hazards that have become important hazards for healthcare workers. (Occup. Med. 2000;50……) HEPATITIS B, VACCINATION AND HEALTHCARE WORKERS (E. Murphy) examined trends in disease prevalence and transmission of mutant strains, evidence of uptake and efficacy of vaccination programme in healthcare workers, management of non-responders to immunization and future issues and developments. Evidence was found for the efficacy and safety of the currently available vaccines in the UK. There is growing evidence that 1 or 2 doses of recombinant vaccines may offer satisfactory immunity with persistent immunological memory in healthy adults. HEPATITIS C VIRUS: AN IMPORTANT OCCUPATIONAL HAZARD (A. Stevens and P.V. Coyle) reviewed the characteristics and prevalence of hepatitis C virus, the clinical history of the associated illness and the risk to patients. There are isolated cases of transmission of the virus from healthcare workers to patients. The authors note that the CDC guidance from the USA recommends obtaining blood from source-patients, after a needlestick injury, to test for anti-HCV, obtaining a baseline and 6-month blood sample from the recipient and confirming the results of first-line HCV tests with RIBA and PCR tests. Post-exposure prophylaxis is not recommended. There is some evidence to support a more active post-exposure management if the source patient is PCR-positive and, therefore, more infectious. Early treatment might improve clearance of the virus. The Advisory Group on hepatitis are keeping the need to issue guidance on the management of infected healthcare workers. Currently, healthcare workers infected with HCV shown to have been associated with transmission of infection to a patient during an EPP should cease to perform such procedures.

OCCUPATIONAL EXPOSURE TO HIV AND POST-EXPOSURE PROPHYLAXIS IN HEALTHCARE WORKERS (I. Kennedy and S. Williams) covered the risk of seroconversion after different types of exposures and the pros and cons of PEP. Aggregated data from a number of studies involving a total of 6202 healthcare workers, followed prospectively after percutaneous exxposure to HIV-infected blood, found that 20 workers (0.32%) became infected. Risk factors associated with an increased risk of seroconversion are 1) deep injury, 2) a device visibly contaminated with patient's blood and 3) a procedure placing a needle in the patient's artery or vein. 8% occupationally-related HIV infections resulted from mucocutaneous exposures. Pooled data suggests a risk of 0.1%. The case for PEP remains in the balance. The authors recommend a risk assessment, taking into account the volume of the innoculum and the status of the source patient. Resistance of *Staphylococci* and *Mycobacterium tuberculosis* to antibiotics was covered by D. Patel and I. Madden. Rates of MRSA infection are increasing worldwide, with the lowest rates in countries with strict infection control policies. Rates of "epidemic" MRSA strains (EMRSA-15 & EMRSA-16) are a cause for concern, as is the emergence of resistance to mupiricin, the mainstay of treatment of nasal carriage. Screening of staff should be risk-based. Resistance of *M. tuberculosis* to at least isoniazid and rifampicin is a worldwide problem. Infection control policies include air handling systems, negative-pressure single isolation rooms and staff usage of suitable particulate masks, e.g. Tecnol PFR95. Occupational health is involved in protecting staff and detecting infection in new and existing staff. JH.

ANHOPS REVIEW

PAPERS REFERENCES

1. Lifelong protection against Hepatitis B: the role of vaccine immunogenicity in immune memory. Vaccine 19 (2001) 877-885

This paper examines the potential to develop life-long immunity to Hep B. It considers the development of immune memory and discusses the need to ensure a good primary immune response to vaccination. The data presented supports the use of highly immunogenic HB vaccines to provide long lasting protection against HB disease. An important consideration in the vaccination of HCW.

2 Doctors suspended after injecting wrong drug into spine. BMJ 3 Feb 2001

Report on recent cases of incorrect administration of cytotoxic agents. This has implications for specific risk assessments within NHS. The DOH is setting up a mandatory system for reporting adverse events and "near misses" through out the NHS.

3 Conquering Hepatitis C, Step by Step. New England Journal of Medicine Vol 343 No 23. 7 Dec 2000.

Looks at current treatments options for patients infected with Hep C – in particular various forms of Interferon therapies. Progress against HCV infection is continuing.

4 Transmission of Hepatitis C virus from a patient to an anaesthesiology assistant to 5 patients. Brief Report. New England Journal of Medicine. Vol 343 No 25. 21 Dec 2000

Describes an "outbreak" of Hep C in a hospital where transmission occurred from infected patient to a non-surgical HCW who then infected 5 other patients. Poor work practices highlighted as a major factor involved in transmission. The transmission of HCV was associated with breaches of infection control and the report identified that universal precautions could have prevented the "outbreak".

5 HIV infections hit a record in UK. BMJ 3.2.01

Article on the increase in the number of HIV cases in the UK in both homosexuals and heterosexuals. The article shows that heterosexuals acquired more new infections than homosexuals did for the second year running. Again, complacency about "safe sex" issues is blamed.

6 President signs needlestick safety prevention act. ACOEM Report. Nov 2000

A step forward in reducing needlestick injuries in the USA with a definition what constitutes a safe medical device and requirements for employers to consider implementing their use. This may have implications for risk assessments within the NHS.

7 Clinical management and the duration of disability for work-related low back pain. JOEM. Vol 42 No 12 Dec 2000.

Paper looking at whether initial clinical management of low back pain affects the duration of disability from it. Findings not consistent with current recommendations (e.g. CSAG/Faculty). The paper suggests the determinants of long term disability associated with lower back pain are not clear and further exploration is needed. Interesting implications for management of low back pain.

WEST MIDLANDS REGION NHS SAFETY HEALTH & ENVIRONMENT (COSHH) MEETING

Dr S Dar and A M Cosgrove.

OPRA 1996-1999

In 1996, the Occupational Physicians' Reporting Activity (OPRA) was established to gather information on the specific types and frequency of ill health seen by occupational physicians. The results of the first 4 years of operation have been reported by Prof. Cherry et al. (Surveillance of work-related diseases by occupational physicians in the UK:OPRA 1996-1999. Occup. Med. 2000;50:496-503) The OPRA reporting card invites reports of new cases seen during the allocated reporting month categorised as RESPIRATORY, SKIN, MUSCULOSKELETAL, HEARING LOSS and OTHER SYSTEMS. Over the 4 years 43,764 estimated new cases were reported. The distribution of reports by diagnostic category confirmed existing perceptions of the importance of musculoskeletal conditions (49.1%) , mental ill health (20.9%) and skin (20%). The most frequently reported conditions were disorders of the hand, wrist and arm, contact dermatitis, disorders of the lumbar spine, anxiety and depression, work-related stress, hearing loss (in men), elbow disorders and asthma. Most of these are relevant to occupational health practice in the NHS and healthcare generally. Analysis by industrial category shows that Health and Social work (25%) had the greatest number of cases of all the 12 categories, with 11,148 reported cases.

Within this standard industrial classification, Lumbar spine and trunk disorders were most frequent (23.6%), followed by Contact dermatitis (16.7%), Anxiety/depression (15%), Other work-related stress (10.8%), hand/wrist/arm disorders (8.1%) and neck/thoracic spine disorders (5.9%).

An important finding is that nurses are one of the most frequently reported occupations in nearly every category of occupational disease. However, this probably reflects that this a large occupational group and that nurses have better access to occupational physicians, generally, compared to some other groups. The authors have used Labour Force Survey data to calculate incidence rates for all occupational diseases and nurses have an annual rate of 183 cases per 100,000 workers. This rate is less than that for other healthcare workers, such as hospital porters (376 per 100,000) and ambulance staff (363 per 100,000). Nonetheless, at a time when sickness absence rates and job retention are priorities for NHS Trusts, absolute numbers are important. Nurses were top of the list of most frequent diagnoses (>5%) for asthma, contact dermatitis, lumbar spine and trunk, neck, anxiety/depression and other work-related stress. This information should assist planning OH activity in the future. JH.